Do Not Staple!

KENTUCKY EMPLOYEES' HEALTH PLAN

ENROLLMENT APPLICATION FOR THE KENTUCKY RETIREMENT SYSTEMS (KRS)

PY 2010

Mail application to:
Perimeter Park West
1260 Louisville Road
Frankfort, KY 40601

INSURANCE COORDINATOR SECTION

__ __ / __ __ / 2 0 1 0
Coverage Effective Date

8 0 0 0 0 (Company Number) ☐ Sp Gen ☐ HD

Reason for Application:

☐< New Retiree	☐< Open Enrollment	☐<QE*	☐< Previously Waived*	☐<Other*

If you previously waived, or marked "Other" or "QE" above, enter the Qualifying Event date _____
Qualifying Event Description _____ Date

Additional Information:

☐ I am covered under a Medicare Supplemental plan through a state sponsored retirement system	☐ I am a retiree returned to work	Is retiree applying for this coverage. ☐< Yes ☐<No	If "No", what is your relationship to the retiree> ☐☐

SECTION I: DEMOGRAPHIC INFORMATION

___ – ___ – ____ _____
RETIREE SSN *(Required)* **RETIREE** Name (First, MI, Last)

___ – ___ – ____ _____
APPLICANT SSN (If retiree is not applying) **APPLICANT** Name (First, MI, Last)

APPLICANT Specific Information

_____ __ __ / __ __ / ____
Mailing Address Date of Birth (MM/DD/YYYY)

_____ _____ _____
City, State, Zip Code County of Residence Country / Mail Code, if not USA

_____ _____ _____
Planholder's HOME PHONE NUMBER Planholder's WORK PHONE NUMBER Planholder's Email Address

Smoking Status (Required)
Have you smoked in the last 2 months? ☐< Yes ☐< No **Gender** ☐ <Male ☐< Female **Marital Status** ☐<Single ☐<Married

SECTION II: PLAN ELECTION- If waiving (i. decline) health insurance coverage, go to Section V.

1. Option (Check only one)	**2. Level of Coverage**	**3. Cross-Reference Payment Option** (Available for Family Coverage Only)
☐ < Commonwealth Standard PPO ☐ < Commonwealth Capitol Choice ☐ < Commonwealth Optimum PPO	☐ < Single ☐ < Parent Plus ☐ < Couple ☐ < Family	☐ < Yes **If Yes, you must complete Sections III and IV** If cross-referenced with an active employee,

SECTION III: SPOUSE AND/OR DEPENDENT INFORMATION → *If you elected Single coverage, skip to Section VII*

Social Security Number	**Name** (First, MI, Last)	**Gender** (Circle one)	**Date of Birth** (MM/DD/YYYY)	**Relationship Code***
		M F		
		M F		
		M F		
		M F		

***Relationship Codes: SP = Spouse, CH = Child, DD = Disabled Dependent, CO = Court-Ordered Dependent**

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Retiree's SSN

			–			–				

Applicant's SSN (from Page1, Section I)

SECTION IV: CROSS-REFERENCE INFORMATION → Complete ONLY if you checked Yes in Section II, box 3

Your Spouse's Company Number: ***(Required)***	Is your spouse a dual employee	Has your spouse smoked in the last 2 months? ***(Required)***	Is your spouse a Hazardous Duty Retiree?	Your spouse's Hire Date or Retirement Date:
_____	☐ <Yes	☐ <Yes ☐ <No	☐ <Yes ☐ <No	_____

SECTION V: WAIVER

Do you wish to waive (i.e. decline) your Health Insurance Coverage? By checking "Yes," I understand that I am declining health insurance coverage through the KEHP ☐ < Yes

SECTION VI: FLEXIBLE SPENDING ACCOUNTS (FSA)

Not Applicable → Retirees are not eligible to participate in a Flexible Spending Account.
Cross-referenced with an active employee who wishes to enroll in an FSA? Please complete the enrollment application for active employees instead.

SECTION VII: AUTHORIZATION AND CERTIFICATION

I understand and agree that:

- If my signature on this application creates a legal and binding contract between myself, the Department of Employee Insurance and the TPA.
- **My spouse and I elect the cross-reference payment option, we are dual planholders with Family coverage and that upon a loss of eligibility by either spouse, the remaining planholder will have the option to enroll in either Single or Parent Plus coverage. The cross-reference payment option ceases upon loss of eligibility or employment by either spouse/planholder.**
- Each dependent I am enrolling meets the eligibility requirements of a dependent as set forth in the plan document and in the KEHP Handbook.
- All benefits for myself and eligible dependents be provided in accordance with the plan document.
- I must abide by the terms and conditions governing membership and receipt of services from the plan in which I have enrolled.
- The elections indicated on this application may not be changed or canceled during the plan year, with the exception of certain Qualifying Events.
- I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected, including any arrears I may owe.
- **I elect to have the employee contribution for health coverage deducted on a pre-tax basis unless I sign a Post-Tax Form or otherwise acknowledge post-tax treatment for my dependents; for Pre-tax treatment, dependent coverage must meet eligibility requirements of Section 152.**
- I authorize the release of medical claims data to the Kentucky Retirement System for use in data analysis and referral to available health related services upon their review.
- I authorize the Retirement System to release the information in this application to the Social Security Administration. The information in this application may be used by the Social Security Administration to determine Medicare eligibility. I further acknowledge the Medicare eligibility may affect my participation in the Kentucky Employees Health Plan.
- This plan has a tobacco incentive for members who do not use tobacco and that this plan offers tobacco cessation programs.
- I have fully read the materials provided to me. My signature below certifies that the statements on this form are true and complete to the best of my knowledge. I acknowledge and understand that DEI will comply with the HIPAA rules and that disclosure of information will be done under the rules of such Federal Law. I further authorize DEI to use such information and to disclose such information to third party administrators, vendors, consultants, governmental with jurisdiction and other necessary parties when necessary for my care or treatment, payment for services, the operation of my health plan or to conduct related activities
- I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for I insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the KEHP and it may be used to reduce or deny a claim or to terminate my coverage. My signature below certifies that all information, signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____
Retiree Signature Date

_____ _____
Applicant Signature (if other than retiree) Date

_____ _____
Spouse Signature – ***REQUIRED*** **if electing the cross-reference payment option** Date

_____ _____
Retirement Insurance Coordinator Signature Date

_____ _____
Spouse's Insurance Coordinator Signature – ***REQUIRED*** **if electing the cross-reference payment option** Date